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Answering Patient Questions about the COVID-19 Vaccine

As COVID-19 vaccines are distributed, providers will be a key part in its adoption and administration to the American public. Patients look to their healthcare professionals for medical guidance and assurance. Your patients will likely have a lot of questions about the vaccine, and as their healthcare provider, they will turn to you for answers. Here are some common questions you may receive.

Q: Can I make an appointment with you to be vaccinated? If not, why? Do I have to go to a pharmacy to receive the vaccine?
A: Pharmacies are generally the most convenient locations to individuals and they also have great expertise in administering vaccines. While many providers anticipate to have the vaccine in their office later on, for now we recommend patients either visit their local pharmacy, register at ourshot.in.gov or call 211.

Q: How do we really know if COVID-19 vaccines are safe?
A: The Food and Drug Administration (FDA) carefully reviews all safety data from clinical trials. It only authorizes emergency vaccine use when the expected vaccine benefits outweigh potential risks. The Advisory Committee on Immunization Practices (ACIP) reviews all safety data before recommending any COVID-19 vaccine for use. FDA and CDC will continue to monitor the safety of COVID-19 vaccines to make sure even very rare side effects are identified.

Q: Is the vaccine that helpful? I heard getting COVID-19 gives you better and longer immunity than the protection a vaccine can give. Can it actually make my illness worse if I do end up getting COVID-19?
A: Explain the potential serious risk COVID-19 infection poses to them and their loved ones if they get the illness or spread it to others.

- Remind them of the potential for long-term health issues after recovery from COVID-19 disease, especially for those who have chronic conditions, are older, or have weakened immune systems.
- Explain that scientists are still learning more about the virus that causes COVID-19. And it is not known whether getting COVID-19 disease will protect everyone against getting it again, or, if it does, how long that protection might last. Therefore getting a vaccine is a safer choice.
- Some vaccines are more effective than the natural illness; it is not clear whether natural illness or vaccination will provide more effective immunity in this case.
- Early information indicates that COVID-19 vaccination may reduce the severity of illness, as well as the incidence of illness. As we learn more about the efficacy of the vaccine, we will also learn more about potential long-term protection it may bring.
- Describe how the vaccine was tested in large clinical trials and what is currently known about its safety and effectiveness.
- Be transparent that the vaccine is not a perfect fix. Patients will still need to practice other precautions like wearing a mask, social distancing, handwashing and other hygiene measures until public health officials say otherwise.

Q: Will the shot hurt? Can it cause you to get sick? I don't want to get the vaccine because it will give me COVID.
A: List the most common side effects from vaccination and how severe they may be (e.g. fever, headache, body aches, and cold symptoms). Emphasize that a fever could be a potential side effect and when to seek medical care.

- Symptoms will typically go away on their own within a week. Let them know when they should seek medical care if their symptoms don't go away.
- Explain that the vaccine cannot give someone COVID-19 as the vaccine does not contain a live coronavirus.
- Explain that side effects are a sign that the immune system is effectively working.

Q: Do I have to pay for my vaccines?
A: No! The vaccine will be at no cost to patients. They will not have to pay for either dose of the COVID-19 vaccine.

Follow Vaccine Updates from Trusted Sources of Truth
- The Centers for Disease Control (CDC)
- National Institutes of Health (NIH)
- The Centers for Medicare and Medicaid (CMS)
- The American Medical Association (AMA)

Culturally and Linguistically Appropriate Services (CLAS)

What are Culturally and Linguistically Appropriate Services? CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of your patients. Additionally, cultural and language difference may engender misunderstanding, lack of compliance or other factors that negatively impact clinical situations.

With the increasing diversity of the U.S. population, physicians are more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services and supportive health care organizations.

Any health provider and healthcare organization addressing mental, social, spiritual and physical well-being can benefit from the adoption and implementation of the National CLAS standards. The Standards aim to advance health equity, improve quality and help eliminate health care disparities by providing a framework for implementing culturally and linguistically (language) appropriate services throughout an organization.

The Standards outline 15 activities for:

- Improving the cultural and linguistic competency of an organization's governance, leadership and workforce.
- Instituting communication and language assistance.
- Promoting engagement, continuous improvement and accountability in a culturally and linguistically appropriate manner.

Where can I learn more about CLAS standards?
MHS is happy to work with providers who want to learn more about CLAS standards. Visit mhsindiana.com's provider helpful links page for more information. Or, you can call MHS Provider Relations for more information, or to schedule an office visit to discuss CLAS standards.

You can also visit:

- minorityhealth.hhs.gov
- in.gov/isdh
- imhc.org
- thinkculturalhealth.hhs.gov

Reminder! Notify MHS of Network Changes

Be sure to notify MHS if you leave our network or have demographic changes. We want to make sure our Find a Provider search is always accurate. Please give us at least 30 days notice before leaving the network so that we can inform our members and help them find a new practitioner. You can submit changes online at mhsindiana.com. Go to For Providers, then click Provider Resources > Demographic Update Tool.

Drug Search Tool

The MHS Pharmacy department wants you to know about our online drug search tool. With this tool, you will be able to quickly determine which drugs are preferred or non-preferred. You will also be able to see if there are any limitations on the drug such as quantity limit, age limit, or if a PA is required. If a PA is required, the search tool will display the link to the PA form and clinical guidelines. The online search tool will also tell you if the drug is a specialty drug and who provides it.

We envision this tool greatly enhancing both the member and provider experience, since now important drug information is just a click away.

You can access the online search tool on the MHS public website:
For Providers
For Members: HIP, HHW, HCC

Benefits with the Provider Portal

Have you logged in to the MHS Secure Provider Portal lately? Remember, as a security precaution, accounts are disabled after 90 days of inactivity.

You can use the MHS Provider Portal to:

- Manage multiple practices under one account
- Check member eligibility
- MHS Reports: Pay for Performance (P4P)
- Refer Member to Case Management and Behavioral Health
- View Payment History and Explanation of Payment Details
- Document Resource Center (Upload document to member record)
- View medical history and gaps in care
- Submit and manage claims and authorizations
- Securely contact a plan representative

Forgot your password?
Use the Forgot Password/Unlock Account feature to log in.

CHECKING IN WITH DR. YANCY

Order urine microalbumin along with the HgbA1c. And, recommend a retinal eye exam appointment for all diabetics.

Dr. Eric A. Yancy
MHS Chief Medical Officer and practicing pediatrician

Clinical Practice and Preventive Health Guidelines

MHS preventive and clinical practice guidelines are evidence-based and based on the health needs of our members and opportunities for improvement identified as part of the QI program. MHS adopts preventive and clinical practice guidelines that are published by nationally recognized organizations or government institutions. These guidelines have been reviewed by our QI committee, which includes representation from MHS network physicians.

We encourage practitioners to use these guidelines as a basis for developing personalized treatment plans for our members and to aid members in making decisions about their healthcare. MHS measures compliance with these guidelines through monitoring of related HEDIS measures and through random ambulatory medical record audits. MHS utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with these guidelines. The adopted guidelines are intended to augment, not replace, sound clinical judgment. Current preventive and clinical practice guidelines are available online at mhsindiana.com, and may be mailed to practitioners as part of disease management or other quality program initiatives. The guidelines are also available upon request to members.

Advance Directives

MHS is committed to ensuring that its members know of, and are able to, avail themselves of their rights to execute advance directives. MHS is equally committed to ensuring that its providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding advance directives.

Any provider delivering care to MHS members must ensure that members receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the member's medical record.

MHS will monitor compliance with this provision. Providers may be audited annually. If you have any questions regarding advance directives, please contact MHS at 1-877-647-4848.

Provider and Practitioner Credentialing Rights and Responsibilities

MHS has a duty to protect members by assuring the care they receive is of the highest quality. One protection is assurance that our providers and practitioners have been credentialed according to the strictest standards established by state regulators and accrediting organizations. Your responsibility as an MHS provider includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

During the credentialing process you have the right to:

- Strict confidentiality of all information submitted.
- Non-discrimination.
- Be notified when information obtained from outside sources varies substantially from what you submitted.
- Review information submitted by outside primary sources such as malpractice insurance carriers and state licensing boards. This excludes references, recommendations or other peer-review protected information.
- Correct erroneous information.
- Be informed of the status of your application.
- Receive notification within 60 days of the Credentialing Committee decision.
- Receive notification of process to appeal an adverse decision.

Further details on credentialing rights and responsibilities as an MHS provider are included in the MHS Provider Manual found on mhsindiana.com.

Helping Members Use Emergency Services Appropriately

MHS wants to help make sure that our members are visiting their primary care doctor for their health needs. To that end, we offer an ER diversion program that is facilitated by our Medical Case Management - Special Needs team. Our Care Managers provide advice about when and where emergent care is appropriate for specific conditions. Members will be outreached to by phone within 10 days of referral.

MHS also offers a free 24-hour nurse advice line to all members. The nurse advice line is available 24 hours a day, seven days a week, including weekends and holidays. Callers can talk to experienced nurses when they call. The main goal of the nurse advice line is to direct members to the appropriate level of care. Staff use state-of-the-art advice protocols and plan methodologies. All calls taken are logged and tracked. Members may call 1-877-647-4848 and follow the prompts to reach the nurse advice line.

If you would like to refer a member to the ER diversion program, please call 1-877-647-4848, ext. 20190.

Advise Smokers to Quit: The 2-Question Approach

Providers are encouraged to discuss tobacco cessation with all patients, advising and imploring smokers to quit. Ask these two simple questions "do you smoke?" and "can I help you quit?" to start a dialogue with your patient about their tobacco use.

MHS covers tobacco cessation counseling when billed with CPT code 99407 and the modifier "U6 - Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes; per 15 minutes". Providers must bill the modifier U6 to denote "per 15 minutes" of service. Prescription cessation aids are covered by the Medicaid program.

Providers are encouraged to refer patients age 18 and over to the Indiana Tobacco Quitline, 1-800-QUIT-NOW. The Quitline offers education and coaching over the phone, and all services are confidential and provided free of charge to Indiana residents. The Quitline staff will fax a report to your office to tell you that the client was enrolled in services. Hoosier Healthwise and Hoosier Care Connect members will earn $20 on their MHS My Health Pays® rewards card just for enrolling with the Quitline. HIP members can earn even more rewards- up to $145 if they complete the program. Ask your Provider Relations Specialist for patient and provider materials that further explain the Quitline program.

About HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison of results across health plans. HEDIS data review allows health plans, providers and key stakeholders to evaluate a wide range of measures related to the timeliness and quality of healthcare services.

Some HEDIS rate calculations are based upon claims data alone, while others utilize a combination of claims data and medical record review. Tips for optimizing HEDIS results include:

- Ensure HEDIS-compliant coding
- Your MHS Provider Relations representative can share reference information as needed
- Utilize the ACOG flowsheet to document prenatal visits
- Utilize opportunities at symptomatic visits to close preventive care gaps as appropriate
- Ensure that the following elements are included in well-child visits:
    - A health history
    - A physical developmental history
    - A mental developmental history
    - A physical exam
    - Health education/anticipatory guidance

Most of all, thank you for your assistance during this year's HEDIS audit activities

Calculating HEDIS Rates

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data.

Accurate and timely claim/encounter data reduces the necessity of medical record review. Measures typically requiring medical record review include:

- Comprehensive diabetes care
- Control of high-blood pressure
- Immunizations-childhood and adolescent
- Prenatal care including initiation of care and post-partum care
- Well-child care
- BMI Assessment

Examples of measures typically calculated using administrative data include:

- Breast cancer screening
- Annual chlamydia screening
- Pap test
- Testing of pharyngitis
- Appropriate treatment for URI
- Medication management of people with asthma
- Antidepressant medication management
- Access to PMP services
- Utilization of acute and mental health services

Pharmacy Preferred Drug List and Procedures

MHS maintains a preferred drug list (PDL) which is updated quarterly by the MHS Pharmacy and Therapeutics Committee. The committee is comprised of Indiana practicing physicians and pharmacists. You may view the PDL on the MHS provider website or through your e-prescribing platform. Medications not listed on the PDL may be available through the prior authorization process and medical necessity review. PA forms are available to you on the MHS website or through CoverMyMeds electronic PA solutions. More information regarding how to make exception requests, generic substitution, therapeutic interchange and step therapy protocols are available in your provider handbook as well as on the MHS provider website.

EPSDT Well-Child Documentation

Ongoing review of both electronic and paper medical records demonstrates that not all of the components of a well-child visit are routinely documented. A standardized well-child template will help facilitate complete documentation to meet EPSDT/(HealthWatch) and HEDIS standards. MHS has created well-child templates for each age group that meet criteria for both HEDIS and EPSDT requirements. The templates are conveniently located on the MHS provider guides page for free download. If you would like paper copies of these templates, please contact your Provider Services Representative.

A complete EPSDT well-child exam requires:

- Health History
- Psychosocial/Family History
- Structured Developmental Screening
- Ongoing Developmental Surveillance
- Depression Screening/Risk Assessment
- Nutritional Assessment
- Physical Activity Assessment
- Measurements
- Physical Examination
- Vision Screening
- Hearing Screening
- Dental Screening
- Anticipatory Guidance/Healthy Education
- Immunizations
- Laboratory Tests

Please refer to the Indiana Medicaid HealthWatch/EPSDT Provider Reference Module for complete guidelines on required screenings and medical record documentation. You can also review our adopted clinical practice and preventive guideline for pediatric preventive care on our Practice Guidelines page. Utilizing a standardized well-child template will help ensure your documentation is complete each and every time.

Required Lead Screenings

Reminder: Providers must perform lead screenings for all children enrolled in Medicaid. This is a federal requirement.

The Family and Social Services Administration (FSSA) requires that all children enrolled under Medicaid receive a blood lead screening test between 9 months and 12 months and again at 24 months of age. If the member is at high risk for lead exposure, the initial screening should be performed at the 6-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months must receive a blood lead screening if they have not been previously tested for lead poisoning. A blood lead test result equal to or greater than 5 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent screenings are required for at-risk patients.

Providers are required to report all results of blood lead tests to the Indiana State Department of Health (ISDH) no later than one week after the screening.

Prior authorization is not required for coverage of screening. For billing recommendations, providers should turn to this reference guide. And for more information on lead poisoning and blood lead screenings, MHS has free brochures that providers can give to their patients. Contact your Provider Relations Representative to request brochures.

Peer-to-Peer Review

MHS will send you and your patient written notification any time we make a decision to deny, reduce, suspend or stop coverage of certain services. The denial letter includes information on the availability of an MHS Medical Director to discuss the denial decision.

In the event that a request for medical services is denied due to lack of medical necessity, a physician can request a peer-to-peer review with the MHS Medical Director on the member's behalf. Requests for peer-to-peer reviews should be made within 10 calendar days of denial notification. To set up a call, please contact the MHS Peer-to-Peer line at 1-855-696-2613.

The denial letter will also inform you and the member about how to file an appeal and how to contact MHS if assistance is needed. In urgent cases, an expedited appeal is available and can be submitted verbally or in writing.

Annual Monitoring for Patients on Persistent Medications

When it comes to medications, safety is very important. This is especially true for our members at an increased risk of adverse medication events from long-term use of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), Digoxin and Diuretics.

Adult members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy must be monitored at least annually.

ACE or ARB: At least one serum potassium and a serum creatinine therapeutic monitoring test in the calendar year.

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set).

Digoxin: At least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test during the calendar year:

- A lab panel test (Lab Panel Value Set) and a serum digoxin test (Digoxin Level Value Set).
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set) and a serum digoxin test (Digoxin Level Value Set).

Diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test during the calendar year:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set).

Note: Tests do not need to occur on the same service date, only within the same calendar year.